



Chapter 8: History Audits 5000-5999

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 31, 1999	All	Update edits and audits	Leanna Collisi and Brandy Ludlum
Version 1.2	June 30, 2000	8-1-2	Updated edits and audits	Leanna Collisi and Brandy Ludlum
Version 2.2	June 30, 2001	8-1-2	Updated audit 5000	Charlene Schweikhart
Version 2.3	September 2001	8-1-10	Updated audit 5001	Charlene Schweikhart
Version 2.4	December 31, 2001	8-1-22 8-1-23	Addition of new Audits 5010 and 5011	Susan Mariutto
Version 3.2	June 28, 2002	Various	Updates to audits 5000 and 5001	Susan Mariutto
Version 4.1	March 2003	Various	Updates to audits 5000, 5001, 5007, 5008, and 5009	Susan Mariutto
Version 4.2	June 2003	8-1-1 and 8-1-2	Updates to audit 5000	Susan Mariutto
Version 4.3	September 2003	Various	Updates to edits 5000, 5001, and 5008	Susan Mariutto
Version 5.2	June 30, 2004	Various	Update edit 5000.	Leo Dabbs
Version 5.3	September 30, 2004	Various	Update edits 5000, 5002, 5003, and 5007.	Leo Dabbs
Version 6.1	March 31, 2005	Various	Update edits 5000, 5001, 5008, 5009, 5010, and 5011.	Leo Dabbs
Version 6.3	October 5, 2005	8-1-101	Update edit 5212.	Leo Dabbs
Version 6.4	December 31, 2005	8-1-2	Update edit 5000.	Leo Dabbs
Version 7.2	June 30, 2006	Various	Update edit 5000 and 5009.	Leo Dabbs
Version 7.3	September 29, 2006	8-1-2	Update edit 5000.	Anson Haley

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Section 1: History Audits 5000-5999

Overview

History audits compare the current claim against paid claims in history to determine if services are submitted in duplicate.

Audit: ESC 5000 Possible Duplicate

<i>Note: Revised Audit 5000 August 1, 2006.</i>

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A,B,C,D,H,I, L,M,O,P,Q	20	All	Detail	Yes	Yes	0

Disposition	A,B,D,H,I, M,O	C	L	P&Q
00 Other				Deny
10 Paper w attach	Suspend	Suspend	Suspend	Deny
20 ECS w attach	Suspend	Suspend	Suspend	Deny
22 Shadow	Inactive	Inactive	Inactive	Inactive
25 Point of Service w/o attach	Suspend	Deny	Suspend	Deny
50 Voids/Replacement non- check related	Suspend	Suspend	Suspend	Pay
51 Voids/Replacement check related	Suspend	Suspend	Suspend	Pay
52 Shadow Replacement	Inactive	Inactive	Inactive	Pay
53 Shadow Claim Void	Suspend	Suspend	Suspend	Pay
55 Mass Replacement NH	Suspend	Suspend	Suspend	Pay
56 Mass Replacement FIN	Suspend	Suspend	Suspend	Pay
90 Special batch	Suspend	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims:

Same rendering provider number, recipient number, overlapping dates of service, same all three digits of the procedure code for procedure codes 10000 thru 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

For dates of service January 1, 2004 and after, same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for crosswalked procedure codes as noted below to replace codes X0001 to X3048, Z5123 to Z5132, including modifiers.

Local Code	Crosswalked Procedure Code
X3005	E0619 NU, E0619 RR
X3011	T2015 U7
X3012	H2023 U7
X3013	T2029 U7 NU
X3014	T2029 U7 RP
X3015	G0152 U7 UA
X3017	G0151 U7 UA
X3019	S5165 U7 NU, T2039 U7
X3020	S5165 U7 RP
X3028	T2003 U9
X3029	T2004 TT
X3030	T2001 TK
X3031	A0100 UA
X3032	A0100 UB
X3033	A0100 UC
X3034	A0100 UA TK
X3035	A0100 UA TT
X3036	A0100 UB TK
X3037	A0100 UB TT
X3038	A0100 UC TK
X3039	A0130 TK
X3040	H0031 HW
X3041	H0002
X3042	H0004 HW
X3044	H004 HW HR, H0004 HW HS
X3045	H0004 HW HQ
X3046	H2011 HW
X3047	H0033 HW
X3048	H2014 HW
Z5123	T2031 U7 U1
Z5124	T2031 U7 U2
Z5125	T2031 U7 U3
Z5128	S5140 U7 U1
Z5129	S5140 U7 U2
Z5130	S5140 U7 U3

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

*Note: The allowed reimbursement amount for each provider should be the **lesser** the RBRVS fee amount times .625 (62.5%), or the billed amount.*

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same first three** digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, **suspend** the claim. Dental claim details that meet the

above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and **deny** for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Effective January 1, 2004 Waiver Codes T2021U7, T2021U7HQ, T2017U7, T2017U7TF, or T2017U7TG, submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

For dates of service January 1, 2004 and after, the procedure code for crosswalked procedure codes as noted below to replace codes Z5163, Z5164, Z5170, Z5171, and Z5172 submitted by different providers should be forced to pay. Procedure codes Z5173, Z5174, Z5175, and Z5176 are no longer covered by the IHCP effective July 1, 2003.

Local Code	Crosswalked Procedure Code
Z5163	T2021 U7
Z5164	T2021 U7 HQ
Z5170	T2017 U7
Z5171	T2017 U7 TF
Z5172	T2017 U7 TG

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

Effective January 1, 2004 Waiver codes T2004U7U1, T2004U7U3, T2004U7U4, T2004U7U6, T2004U7U8 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

For dates of service January 1, 2004 and after, for crosswalked procedure codes as noted below to replace codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be **forced** to pay.

Local Code	Crosswalked Procedure Code
Z5195	T2004 U7 U1
Z5196	T2004 U7 U3
Z5197	T2004 U7 U4
Z5198	T2004 U7 U6
Z5199	T2004 U7 U8

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate claim/service.

Remark Code

None

NCPDP REJECT CODE:

83- Duplicate paid/captured claim

Method of Correction

- There are several methods of corrections that will pertain to the different claim types, please work appropriately.
- NOTE: If the related ICN is a Shadow or Encounter Claim (Region 22), Deny the claim with EOB 2017 and give the ICN to Team Lead.
- Click on the related ICN(s) in the related history box. Related History could be associated with the same or different ICN. The following methods of correction apply to both situations.
- Compare the procedure codes on the suspended claim and related history ICN. If the procedures are different. **Force** the claim to pay.
- If the procedure codes are the same on both claims, and there is no modifier on either claim. **Deny** the claim.
- If there is a modifier on both claims, look on the modifier sheet to see if the modifiers are different. If the modifiers are different, force to pay. If the modifiers are the same, **deny** the claim.
- If one claim contains a surgical procedure code in the surgery range of 10000-69999 and the other claim contains the same surgical procedure code with a modifier of AA or 80. **Force** the claim to pay. If the one claim has QK and the other claim has QX, force the claim to pay.
- Supply codes E1340, E1399 or B9999 look at billed amount if they are different. **Force** to pay.
- Supply codes E1340, E1399, or B9999 that have the same dates of service and the same-billed amount. **Deny** the claim.

Modifier 62:

- If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two Surgeons), for the same recipient and on the same date of service, the audit can be **forced** for payment. The current claim and history claim must both have modifier 62. If one of the claims does not have a modifier 62, **deny** the claim.

Case Management Claims:

- There are new case management codes: G9012, H0004HW, H0004HW HS, H0004HR, H0004 U7, H0031HW, H0004HW HQ, H2011HW, H0033HW, H0035HW, T1016HW, 97535 HW HQ, 97537 HW HQ,

- These codes have to be billed with the modifiers, which identifies them as PIC's
- If the billing provider numbers are the same, **deny** the claim. If the billing provider numbers are different, **Force** the claim to pay.
- (X3048-X3050), these codes should be Forced if the provider numbers are different. Even if the procedure has the same modifier. These codes are not in effect after 1/1/04. The new case management codes are in effect 10/16/03.
- If the billing provider numbers are the same, look to see if the rendering provider is different. If rendering provider is different. **Force** the claim to pay. If the rendering provider is the same, look at the modifier (remember to check the modifier list for the meaning of the modifiers). If the modifier makes the claim different, force the claim to pay. If everything on the claim, matches **deny** the claim.
- If the billing provider numbers are different, **force** the claim to pay.

WAIVER CODES:

- New Waiver Codes Effective 1/1/2004
- H0032 U7 U1, T2015 U7, T2021 U7, T2021 U7 HQ, T2021U7 UA, T2021 U7 UA HQ, T2017 U7, T2017 U7 TF, T2017 U7 TG, T2004 U7 U1, T2004 U7 U3, T2004 U7 U4, T2004 U7 U6, T2004 U7 U8, T1016 U7, S5130 U7 UA, S5125 UA U7, S5150 U7 UA, T1005 U7 UA, S5125 U7 UA, T1016 U7, T2021 U7, T2021 U7 HQ, H0004 U7, S5150 U7 HQ
- If the billing provider numbers are the same, look to see if the rendering provider is different. If the rendering provider is different, **Force** the claim to pay. If the rendering provider is the same, look at the modifier (remember to check the modifier list for the meaning of the modifiers). If the modifier makes the claim, different, force the claim to pay. If everything on the claim matches, **deny** the claim. If the billing provider numbers are different, **Force** the claim to pay.
- Z5163, Z5164, Z5165, Z5166, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176, Z5190, Z5195, Z5196, Z5197, Z5198, Z5199, Z5202, Z5604, Z5701, Z5702, and Z5726, it submitted by different providers for the same date of service cannot be used after 12/31/03.
- If the billing provider numbers are the same, Deny the claim. If the billing provider numbers are different, **Force** the claim to pay. Modifier TC and 26:
- If one procedure code, has a modifier of 26 and the other procedure code is billed with a TC modifier, **Force** the claim to pay.
- If the procedure code is one of the following CPT clinical lab codes, and one claim is billed with modifier 26 (Professional Component) and one claim is billed without a modifier, **force** the claim to pay.
- Table 1
- 83020 83912 84165 84166 84181
- 84182 85390 85576 86255 86256
- 86320 86325 86327 86334 86335
- 87164 87207 88371 88372 89060
- With the exception of the procedure codes listed in Table 1, above, if one procedure code is billed with no modifier and the other procedure code is billed with a 26 or TC modifier. **Deny** the claim.

- If the procedure code and the modifier are the same on both claims, **Deny** the claim.
- Remember the procedure code has to be the same on both claims.

First Step Claims:

- **Check the billing provider number, if the provider numbers are different, Force the claim to pay.**
- **If the billing provider numbers are the same, look at the rendering provider numbers, if the rendering provider numbers are different. Force the claim to pay.**
- **If the billing provider number and the rendering provider numbers are the same on both claims, Deny the claim.**

MRT Claims:

- **For Procedure Code S9981, check the billing provider number, if the provider number is different, Force the claim to pay. If the billing provider numbers are the same, look at the rendering provider numbers, if the rendering provider numbers are different. Force the claim to pay.**
- **If the billing provider number and the rendering provider numbers are the same on both claims, Deny the claim.**

Outpatient Claims:

- Note: If the related ICN is a Shadow or Encounter Claim (Region 22), **Deny** the claim with EOB 2017 and give the ICN to Team Lead.

Outpatient Versus LTC:

- Click on the related ICN(s) in the related history box.
- Check to see if the revenue codes are different. If different revenue codes. **Force** The claim to pay.
- Check the revenue codes, if the same revenue code is billed, and the procedure code is the same, **Deny** the claim.
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.

Outpatient versus Inpatient/X-Over Inpatient:

- Click on the related ICN(s) in the related history box.
- If the dates are overlapping and the providers are the same or different. **Deny** the claim.
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same Deny the claim. If the billed amount is different on revenue code 250, **Force** to pay.

Ancillary Dupes:

- ***** Please pay attention to the guidelines below*****
- If the ancillaries are already paid when a surgery code claim suspends:
- **Force** the duplicate audit.
- Write up an adjustment for the ancillary claim.

- Write the adjustment to recoup the dollar amount for the ancillary revenue code charges only.
- If the surgery claim has already been paid and the claim with ancillary codes suspend:
- **Deny** the ancillary claim.
- Add the EOB 5012

Outpatient versus Home Health:

- Click on the related ICN (s) in the related history box
- Check to see if the revenue codes are different. If different revenue code. **Force** to pay.
- Check the revenue codes, if the same revenue code and procedure code are billed, not different. **Deny** the claim.
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.

Outpatient versus Outpatient/X-over Outpatient:

- Click on the related ICN (s) in the related history box.
- If the related history ICN is the same as the suspended ICN. **Force** to Pay.
- Look at the revenue code if different. **Force** to pay.
- If the revenue codes are the same. **Deny**
- If the revenue codes are the same, but one claim has a procedure code. **Deny**
- If revenue codes are the same, but the procedure code is different. **Force** the claim to pay.
- If the revenue code is different, but in the same revenue group, and the procedure code is the same. **Deny** the claim. *Example: Suspended claim has 301-81000 and the history claim has 307-81000.*
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.

Outpatient X-Overs versus Outpatient X-Overs:

- Click on the related history claim(s).
- Check the dates of service
- Check the revenue/procedure codes
- If the revenue codes are on both claims. **Deny**
- If the revenue codes are different. **Force** to pay.
- If one of the claims has a procedure code with the revenue code. **Deny**
- If a claim has the same revenue code, but, with different procedure codes. **Force** the claim to pay.
- If the revenue code is different, but, in the same revenue group and the procedure code is the same. **Deny** the claim. *Example: Suspended claim has 301- 81000, and the history claim has 307-81000.*

- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same Deny the claim. If the billed amount is different on revenue code 250, **Force** to pay.

LTC Claims:

- Note: If the related ICN is a Shadow or Encounter Claim (Region 22), Deny the claim with EOB 2017 and give the ICN to Team Lead.

LTC versus LTC:

- Check the dates of service
- If the date of service is a continuation. (Remember a continuation is where the date on one claim is the date on the other claim. Look at the patient status code. If the status code states that the recipient was discharged or transferred. **Force** the claim.
- If the status code is 30 on both claims. **Deny** the claim
- If the dates of service are overlapping, look at the revenue codes
- If different revenue codes. **Force** the claim to pay
- If the revenue codes are the same. **Deny** the claim
- If the related history ICN is the same as the suspended ICN. **Force** to pay
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.
- One bed rate revenue codes: 100-179, 200-219, and 230-239. These revenue codes cannot be billed on the same dates of service. You cannot be in two beds at the same time. Exception: If one of the claims is long-term care claim, and the provider is billing leave days (180-185), claim can be Forced.

LTC Versus Inpatient/X-Over Inpatient:

- Click on the related history claim(s).

Check dates of service.

- If the dates of service looks like a continuation, (if the last date of service is the beginning date of the other claim), then check the status code to verify that it is a discharge. **Force** to pay.
- If the current claim and the related claim(s) have a bed revenue code. Check to see if there are leave day revenue codes (180-185) billed on the LTC claim. If the leave days equal or exceed the days for the hospital claim. **Force** to pay.
- If no leave days are on the LTC claim, and the dates of service are the same as the hospital claim with the same revenue codes. **Deny** the claim.
- If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days of the hospital stay. **Force** to pay.
- *Exception:* If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.

- NOTE: Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claims have four days, the leave days on the LTC claim, must equal four or more units. **Force** to pay.
- On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time. Exception: If one of the claims is a long-term care claim and the provider is billing leave days.

HOME HEALTH:

- Note: If the related ICN is a Shadow or Encounter Claim (Region 22), **Deny** the claim with EOB 2017 and give the ICN to Team Lead.

Home Health Versus Home Health/Outpatient:

- Click on the related ICN(s) in the related history box
- Check the revenue codes.
- If revenue codes are different. **Force** to pay.
- If the same revenue code, check to see if there is a procedure code. If the procedure code is different. **Force** to pay.
- If the revenue code is the same and the procedure code is the same. Check to see if the procedure code is billed with modifiers. If the modifier is different. **Force** to pay.
- If the procedure code and the modifier are the same. **Deny** the claim.
Exception: If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same, **Deny** the claim. If the billed amount is different on revenue code 250, **Force** to pay.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised April 18, 2006.</i>

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
00 Other				Deny
10 Paper w/o attach	Suspend	Suspend	Suspend	Deny
20 ECS w/o attach	Suspend	Suspend	Suspend	Deny
22 Shadow	Inactive	Inactive	Pay	Pay
25 Point of Service w/o attach	Suspend	Deny	Suspend	Deny
50 Voids/Replacment non-check related	Suspend	Suspend	Suspend	Pay
51 Voids/Replacement check related	Suspend	Suspend	Suspend	Pay
52 Shadow Replacement	Inactive	Inactive	pay	Pay
53 Shadow Claim Void	Suspend	Suspend	Suspend	Pay
55 Mass Replacement NH	Suspend	Suspend	Suspend	Pay
56 Mass Replacement FIN	Suspend	Suspend	Suspend	Pay
90 Special Batch	Suspend	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle; fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048,, Z5123 to Z5132, including modifiers.

For dates of service January 1, 2004 and after, same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for crosswalked procedure codes as noted below to replace codes X0001 to X3048, Z5123 to Z5132, including modifiers.

Local Code	Crosswalked Procedure Code
X3005	E0619 NU, E0619 RR
X3011	T2015 U7
X3012	H2023 U7
X3013	T2029 U7 NU
X3014	T2029 U7 RP
X3015	G0152 U7 UA
X3017	G0151 U7 UA
X3019	S5165 U7 NU, T2039 U7
X3020	S5165 U7 RP
X3028	T2003 U9
X3029	T2004 TT
X3030	T2001 TK
X3031	A0100 UA
X3032	A0100 UB
X3033	A0100 UC
X3034	A0100 UA TK
X3035	A0100 UA TT
X3036	A0100 UB TK
X3037	A0100 UB TT
X3038	A0100 UC TK
X3039	A0130 TK
X3040	H0031 HW
X3041	H0002
X3042	H0004 HW
X3044	H004 HW HR, H0004 HW HS
X3045	H0004 HW HQ
X3046	H2011 HW
X3047	H0033 HW
X3048	H2014 HW
Z5123	T2031 U7 U1
Z5124	T2031 U7 U2
Z5125	T2031 U7 U3
Z5128	S5140 U7 U1
Z5129	S5140 U7 U2
Z5130	S5140 U7 U3

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for

the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

Note: The allowed reimbursement amount for each provider should be the lesser of the RBRVS fee amount times .625 (62.5%), or the billed amount.

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same

tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Effective January 1, 2004 Waiver Codes T2021U7, T2021U7HQ, T2017U7, T2017U7TF, or T2017U7TG, submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

For dates of service January 1, 2004 and after, the procedure code for crosswalked procedure codes as noted below to replace codes Z5163, Z5164, Z5170, Z5171, and Z5172 submitted by different providers should be forced to pay. Procedure codes Z5173, Z5174, Z5175, and Z5176 are no longer covered by the IHCP effective July 1, 2003.

Local Code	Crosswalked Procedure Code
Z5163	T2021 U7
Z5164	T2021 U7 HQ
Z5170	T2017 U7
Z5171	T2017 U7 TF
Z5172	T2017 U7 TG

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

Effective January 1, 2004 Waiver codes T2004U7U1, T2004U7U3, T2004U7U4, T2004U7U6, T2004U7U8 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

For dates of service January 1, 2004 and after, for crosswalked procedure codes as noted below to replace codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay.

Local Code	Crosswalked Procedure Code
Z5195	T2004 U7 U1
Z5196	T2004 U7 U3
Z5197	T2004 U7 U4

Z5198	T2004 U7 U6
Z5199	T2004 U7 U8

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate claim/service.

Remark Code

None

NCPDP Reject Code

83 – Duplicate paid/captured claim.

Method of Correction

There are several methods of corrections that will pertain to the different claim types, please work appropriately.

NOTE: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017, and give the ICN to Team Lead.

Click on the related ICN(s) in the related history box. Related History could be associated with the same or different ICN. The following methods of correction apply to both situations.

Compare the procedure codes on the suspended claim and related history ICN. If the procedures are different. Force the claim to pay.

If the procedure codes are the same on both claims, and there is no modifier on either claim. Deny the claim.

If there is a modifier on both claims, look on the modifier sheet to see if the modifiers are different. If the modifiers are different, force to pay. If the modifiers are the same, deny the claim.

If one claim contains a surgical procedure code in the surgery range of 10000-69999 and the other claim contains the same surgical procedure code with a modifier of AA or 80. Force the claim to pay.

Supply codes E1340, E1399, or B9999 look at billed amount if they are different. Force to pay.

Supply codes E1340, E1399, or B9999 have the same dates of service and the same-billed amount. Deny the claim.

Modifier 62:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two Surgeons), for the same recipient, and on the same date of service, the audit can be forced for payment. The current claim and history claim must both have modifier 62. If one of the claims does not have a modifier 62, deny the claim.

Case Management Claims:

There are new case management codes: G9012, H0004HW, H0004HW HS, H0004HR, H0004 U7, H0031HW, H0004HW HQ, H2011HW, H0033HW, H0035HW, T1016HW, 97535 HW HQ, 97537 HW HQ.

These codes have to be billed with the modifiers, which identifies them as PICs.

If the billing provider numbers are the same, deny the claim. If the billing provider numbers are the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

(X3048-X3050), these codes should be Forced if the provider numbers are different, even if the procedure has the same modifier. These codes are not in effect after 1/1/04. The new case management codes are in effect 10/16/03.

If the billing provider numbers are the same, look to see if the rendering provider is different. If rendering provider is different, force the claim to pay. If the rendering provider is the same, look at the modifier (remember to check the modifier list for the meaning of the modifiers). If the modifier makes the claim different, force the claim to pay. If everything on the claim, matches deny the claim. If the billing provider numbers are different, force the claim to pay.

Waiver Codes:

New Waiver Codes Effective 1/1/2004:

H0032 U7 U1, T2015 U7, T2021 U7, T2021 U7 HQ, T2021U7 UA, T2021 U7 UA HQ, T2017 U7, T2017 U7 TF, T2017 U7 TG, T2004 U7 U1, T2004 U7 U3, T2004 U7 U4, T2004 U7 U6, T2004 U7 U8, T1016 U7, S5130 U7 UA, S5125 UA U7, S5150 U7 UA, T1005 U7 UA, S5125 U7 UA, T1016 U7, T2021 U7, T2021 U7 HQ, H0004 U7, S5150 U7 HQ.

If the billing provider numbers are the same, look to see if the rendering provider is different. If the rendering provider is different, force the claim to pay. If the rendering provider is the same, look at the modifier (remember to check the modifier list for the meaning of the modifiers). If the modifier makes the claim, different, force the claim to pay. If everything on the claim matches, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Z5163, Z5164, Z5165, Z5166, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176, Z5190, Z5195, Z5196, Z5197, Z5198, Z5199, Z5202, Z5604, Z5701, Z5702, and Z5726, if submitted by different providers for the same date of service, cannot be used after 12/31/03.

If the billing provider numbers are the same, deny the claim. If the billing provider numbers are different, force the claim to pay.

Modifier TC and 26:

If one procedure code, has a modifier of 26 and the other procedure code is billed with a TC modifier, force the claim to pay.

If the procedure code is one of the following CPT clinical lab codes, and one claim is billed with modifier 26 (Professional Component) and one claim is billed without a modifier, force the claim to pay.

83020	83912	84165	84166	84181
84182	85390	85576	86255	86256
86320	86325	86327	86334	86335
87164	87207	88371	88372	89060

With the exception of the procedure codes listed in Table 1, above, if one procedure code is billed with no modifier and the other procedure code is billed with a 26 or TC modifier. Deny the claim.

If the procedure code and the modifier are the same on both claims, Deny the claim.

Remember the procedure code has to be the same on both claims.

Outpatient versus LTC:

Click on the related ICN(s) in the related history box.

Check to see if the revenue codes are different. If different revenue codes, force to pay.

Check the revenue codes if the same revenue code is billed, and the procedure code is the same as well, deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Inpatient/X-Over Inpatient:

Click on the related ICN(s) in the related history box.

If the date are overlapping and the providers are the same or different. Deny the claim.

Exception: If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same Deny the claim. If the billed amount is different on revenue code 250, Force to pay.

Ancillary Dupes:

If the ancillaries are already paid when a surgery code claim suspends:

Force the duplicate audit.

Write up an adjustment for the ancillary claim.

Write the adjustment to recoup the dollar amount for the ancillary revenue code charges only.

If the surgery claim has already been paid and the claim with ancillary codes suspend, then:

Deny the ancillary claim.

Add the EOB 5012

Outpatient versus Home Health:

Click on the related ICN (s) in the related history box.

Check to see if the revenue codes are different. If different revenue code, force to pay. Check the revenue codes. If the same revenue code and procedure code are billed, not different, deny the claim.

Check the revenue codes, if the same revenue code and procedure code are billed, not different. Deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Outpatient/X-over Outpatient:

Click on the related ICN (s) in the related history box.

If the dates are overlapping, deny the claim.

If the related history ICN is the same as the suspended ICN, force to Pay.

Look at the revenue code. If different., force to pay.

If the revenue codes are the same, deny the claim.

If the revenue codes are the same, but one claim has a procedure code, deny the claim.

If revenue codes are the same, but the procedure code is different, force the claim to pay.

If the revenue code is different, but in the same revenue group, and the procedure code is the same, deny the claim. *Example: Suspended claim has 301-81000 and the history claim has 307-81000.*

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient X-Overs versus Outpatient X-Overs:

Click on the related history claim(s).

Check the dates of service.

Check the revenue/procedure codes.

If the revenue codes are on both claims. Deny the claim.

If the revenue codes are different, force to pay.

If one of the claims has a procedure code with the revenue code, deny the claim.

If a claim has the same revenue code, but, with different procedure codes, force the claim to pay.

If the revenue code is different, but, in the same revenue group and the procedure code is the same, deny the claim. *Example: Suspended claim has 301- 81000, and the history claim has 307-81000.*

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

LTC Claims:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017 and give the ICN to Team Lead.

LTC versus LTC:

Check the dates of service

If the date of service is a continuation. Remember a continuation is where the to date on one claim is the from date on the other claim. Look at the patient status code. If the status code states that the recipient was discharged or transferred, force the claim.

Look at the patient status code. If the status code states that the recipient was discharged or transferred, force the claim to pay.

If the status code is 30 on both claims, deny the claim.

If the dates of service are overlapping, look at the revenue codes.

If different revenue codes, force the claim to pay.

If the revenue codes are the same, deny the claim.

If the related history ICN is the same as the suspended ICN, force to pay.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

One bed rate revenue codes: 100-179, 200-219, and 230-239. These revenue codes cannot be billed on the same dates of service. You cannot be in two beds at the same time. *Exception:* If one of the claims is a long-term care claim, and the provider is billing leave days (180-185), then the claim can be forced.

LTC versus Inpatient/X-Over Inpatient:

Click on the related history claim(s).

Check dates of service.

If the dates of service look like a continuation, (if the last date of service is the beginning date of the other claim), then check the status code to verify that it is a discharge, and then force to pay.

If the dates of service are the same and the revenue codes are different and they are not the bed revenue codes (look at the list below for bed revenue codes), force the claim to pay.

If the current claim and the related claim(s) has the bed revenue code. Check to see if there are leave day revenue codes (180-185) billed on the LTC claim. If the leave days equal or exceed the days for the hospital claim, force to pay.

If no leave days are on the LTC claim, and the dates of service are the same as the hospital claim with the same revenue codes, deny the claim.

If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days of the hospital stay.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount, if they are the same, deny the claim. If the billed amount is different on revenue code 250, Force to pay.

NOTE: Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claims have four days, the leave days on the LTC claim, must equal four or more units, force to pay.

On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time. Exception: If one of the claims is a long-term care claim and the provider is billing leave days.

HOME HEALTH:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), then deny the claim with EOB 2017 and give the ICN to the Team Lead.

Home Health versus Home Health/Outpatient:

Click on the related ICN(s) in the related history box.

Check the revenue codes.

Check to see if the revenue codes are different. If different revenue codes, force to pay.

If the same revenue code, check to see if there is a procedure code. If the procedure code is different., force to pay.

If the revenue code is the same and the procedure code is the same. Check to see if the procedure code is billed with modifiers. If the modifier is different, force to pay.

If the procedure code and the modifier are the same, deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised November 16, 2005.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Suspend	Suspend	Deny
ECS	Suspend	Suspend	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Suspend	Suspend	Suspend	Deny
Special Batch	Suspend	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle; fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048,, Z5123 to Z5132, including modifiers.

For dates of service January 1, 2004 and after, same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for crosswalked procedure codes as noted below to replace codes X0001 to X3048, Z5123 to Z5132, including modifiers.

Local Code	Crosswalked Procedure Code
X3005	E0619 NU, E0619 RR
X3011	T2015 U7
X3012	H2023 U7
X3013	T2029 U7 NU

X3014	T2029 U7 RP
X3015	G0152 U7 UA
X3017	G0151 U7 UA
X3019	S5165 U7 NU, T2039 U7
X3020	S5165 U7 RP
X3028	T2003 U9
X3029	T2004 TT
X3030	T2001 TK
X3031	A0100 UA
X3032	A0100 UB
X3033	A0100 UC
X3034	A0100 UA TK
X3035	A0100 UA TT
X3036	A0100 UB TK
X3037	A0100 UB TT
X3038	A0100 UC TK
X3039	A0130 TK
X3040	H0031 HW
X3041	H0002
X3042	H0004 HW
X3044	H004 HW HR, H0004 HW HS
X3045	H0004 HW HQ
X3046	H2011 HW
X3047	H0033 HW
X3048	H2014 HW
Z5123	T2031 U7 U1
Z5124	T2031 U7 U2
Z5125	T2031 U7 U3
Z5128	S5140 U7 U1
Z5129	S5140 U7 U2
Z5130	S5140 U7 U3

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

Note: The allowed reimbursement amount for each provider should be the lesser of the RBRVS fee amount times .625 (62.5%), or the billed amount.

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Effective January 1, 2004 Waiver Codes T2021U7, T2021U7HQ, T2017U7, T2017U7TF, or T2017U7TG, submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

For dates of service January 1, 2004 and after, the procedure code for crosswalked procedure codes as noted below to replace codes Z5163, Z5164, Z5170, Z5171, and Z5172 submitted by different providers should be forced to pay. Procedure codes Z5173, Z5174, Z5175, and Z5176 are no longer covered by the IHCP effective July 1, 2003.

Local Code	Crosswalked Procedure Code
Z5163	T2021 U7
Z5164	T2021 U7 HQ
Z5170	T2017 U7
Z5171	T2017 U7 TF
Z5172	T2017 U7 TG

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

Effective January 1, 2004 Waiver codes T2004U7U1, T2004U7U3, T2004U7U4, T2004U7U6, T2004U7U8 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

For dates of service January 1, 2004 and after, for crosswalked procedure codes as noted below to replace codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay.

Local Code	Crosswalked Procedure Code
Z5195	T2004 U7 U1
Z5196	T2004 U7 U3
Z5197	T2004 U7 U4
Z5198	T2004 U7 U6
Z5199	T2004 U7 U8

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate claim/service.

Method of Correction

There are several methods of corrections that will pertain to the different claim types, please work appropriately.

NOTE: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017, and give the ICN to Team Lead.

Click on the related ICN(s) in the related history box. Related History could be associated with the same or different ICN. The following methods of correction apply to both situations.

Compare the procedure codes on the suspended claim and related history ICN. If the procedures are different. Force the claim to pay.

If the procedure codes are the same on both claims, and there is no modifier on either claim. Deny the claim.

If there is a modifier on both claims, look on the modifier sheet to see if the modifiers are different. If the modifiers are different, force to pay. If the modifiers are the same, deny the claim.

If one claim contains a surgical procedure code in the surgery range of 10000-69999 and the other claim contains the same surgical procedure code with a modifier of AA or 80. Force the claim to pay.

Supply codes E1340, E1399, or B9999 look at billed amount if they are different. Force to pay.

Supply codes E1340, E1399, or B9999 have the same dates of service and the same-billed amount. Deny the claim.

Modifier 62:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two Surgeons), for the same recipient, and on the same date of service, the audit can be forced for payment. The current claim and history claim must both have modifier 62. If one of the claims does not have a modifier 62, deny the claim.

Case Management Claims:

There are new case management codes: G9012, H0004HW, H0004HW HS, H0004HR, H0004 U7, H0031HW, H0004HW HQ, H2011HW, H0033HW, H0035HW, T1016HW, 97535 HW HQ, 97537 HW HQ.

These codes have to be billed with the modifiers, which identifies them as PICs.

If the billing provider numbers are the same, deny the claim. If the billing provider numbers are the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

(X3048-X3050), these codes should be Forced if the provider numbers are different, even if the procedure has the same modifier. These codes are not in effect after 1/1/04. The new case management codes are in effect 10/16/03.

If the billing provider numbers are the same, deny the claim. If the billing provider number is the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Waiver Codes:

New Waiver Codes Effective 1/1/2004:

H0032 U7 U1, T2015 U7, T2021 U7, T2021 U7 HQ, T2021U7 UA, T2021 U7 UA HQ, T2017 U7, T2017 U7 TF, T2017 U7 TG, T2004 U7 U1, T2004 U7 U3, T2004 U7 U4, T2004 U7 U6, T2004 U7 U8, T1016 U7, S5130 U7 UA, S5125 UA U7, S5150 U7 UA, T1005 U7 UA, S5125 U7 UA, T1016 U7, T2021 U7, T2021 U7 HQ, H0004 U7, S5150 U7 HQ.

If the billing provider numbers are the same, look at the billing provider number on both claims. If the rendering provider number is the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Z5163, Z5164, Z5165, Z5166, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176, Z5190, Z5195, Z5196, Z5197, Z5198, Z5199, Z5202, Z5604, Z5701, Z5702, and Z5726, if submitted by different providers for the same date of service, cannot be used after 12/31/03.

If the billing provider numbers are the same, deny the claim. If the billing provider numbers are different, force the claim to pay.

Modifier TC and 26:

If one procedure code, has a modifier of 26 and the other procedure code is billed with a TC modifier, force the claim to pay.

If the procedure code is one of the following CPT clinical lab codes, and one claim is billed with modifier 26 (Professional Component) and one claim is billed without a modifier, force the claim to pay.

83020	83912	84165	84166	84181
84182	85390	85576	86255	86256
86320	86325	86327	86334	86335
87164	87207	88371	88372	89060

With the exception of the procedure codes listed in Table 1, above, if one procedure code is billed with no modifier and the other procedure code is billed with a 26 or TC modifier. Deny the claim.

If the procedure code and the modifier are the same on both claims, Deny the claim.

Remember the procedure code has to be the same on both claims.

Outpatient versus LTC:

Click on the related ICN(s) in the related history box.

Check to see if the revenue codes are different. If different revenue codes, force to pay.

Check the revenue codes if the same revenue code is billed, and the procedure code is the same as well, deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Inpatient/X-Over Inpatient:

Click on the related ICN(s) in the related history box.

If the date are overlapping and the providers are the same or different. Deny the claim.

Exception: If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same Deny the claim. If the billed amount is different on revenue code 250, Force to pay.

Ancillary Dupes:

If the ancillaries are already paid when a surgery code claim suspends:

Force the duplicate audit.

Write up an adjustment for the ancillary claim.

Write the adjustment to recoup the dollar amount for the ancillary revenue code charges only.

If the surgery claim has already been paid and the claim with ancillary codes suspend, then:

Deny the ancillary claim.

Add the EOB 5012

Outpatient versus Home Health:

Click on the related ICN (s) in the related history box.

Check to see if the revenue codes are different. If different revenue code, force to pay. Check the revenue codes. If the same revenue code and procedure code are billed, not different, deny the claim.

Check the revenue codes, if the same revenue code and procedure code are billed, not different. Deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Outpatient/X-over Outpatient:

Click on the related ICN (s) in the related history box.

If the dates are overlapping, deny the claim.

If the related history ICN is the same as the suspended ICN, force to Pay.

Look at the revenue code. If different., force to pay.

If the revenue codes are the same, deny the claim.

If the revenue codes are the same, but one claim has a procedure code, deny the claim.

If revenue codes are the same, but the procedure code is different, force the claim to pay.

If the revenue code is different, but in the same revenue group, and the procedure code is the same, deny the claim. *Example: Suspended claim has 301-81000 and the history claim has 307-81000.*

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient X-Overs versus Outpatient X-Overs:

Click on the related history claim(s).

Check the dates of service.

Check the revenue/procedure codes.

If the revenue codes are on both claims. Deny the claim.

If the revenue codes are different, force to pay.

If one of the claims has a procedure code with the revenue code, deny the claim.

If a claim has the same revenue code, but, with different procedure codes, force the claim to pay.

If the revenue code is different, but, in the same revenue group and the procedure code is the same, deny the claim. *Example: Suspended claim has 301- 81000, and the history claim has 307-81000.*

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

LTC Claims:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017 and give the ICN to Team Lead.

LTC versus LTC:

Check the dates of service

If the date of service is a continuation. Remember a continuation is where the to date on one claim is the from date on the other claim. **Look at the patient status code. If the status code states that the recipient was discharged or transferred, force the claim.**

Look at the patient status code. If the status code states that the recipient was discharged or transferred, force the claim to pay.

If the status code is 30 on both claims, deny the claim.

If the dates of service are overlapping:, look at the revenue codes.

If different revenue codes, force the claim to pay.

If the revenue codes are the same, deny the claim.

If the related history ICN is the same as the suspended ICN, force to pay.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

One bed rate revenue codes: 100-179, 200-219, and 230-239. These revenue codes cannot be billed on the same dates of service. You cannot be in two beds at the same time. Exception: If one of the claims is a long-term care claim, and the provider is billing leave days (180-185), then the claim can be forced.

LTC versus Inpatient/X-Over Inpatient:

Click on the related history claim(s).

Check dates of service.

If the dates of service look like a continuation, (if the last date of service is the beginning date of the other claim), then check the status code to verify that it is a discharge, and then force to pay.

If the dates of service are the same and the revenue codes are different and they are not the bed revenue codes (look at the list below for bed revenue codes), force the claim to pay.

If the current claim and the related claim(s) has the bed revenue code. Check to see if there are leave day revenue codes (180-185) billed on the LTC claim. If the leave days equal or exceed the days for the hospital claim, force to pay.

If no leave days are on the LTC claim, and the dates of service are the same as the hospital claim with the same revenue codes, deny the claim.

If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days of the hospital stay.

Exception: If the revenue code is 250, which is drug supply), look at the billed amount, if they are the same, deny the claim. If the billed amount is different on revenue code 250, Force to pay.

NOTE: Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claims have four days, the leave days on the LTC claim, must equal four or more units, force to pay.

On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time. Exception: If one of the claims is a long-term care claim and the provider is billing leave days.

HOME HEALTH:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), then deny the claim with EOB 2017 and give the ICN to the Team Lead.

Home Health versus Home Health/Outpatient:

Click on the related ICN(s) in the related history box.

Check the revenue codes.

Check to see if the revenue codes are different. If different revenue codes, force to pay.

If the same revenue code, check to see if there is a procedure code. If the procedure code is different., force to pay.

If the revenue code is the same and the procedure code is the same. Check to see if the procedure code is billed with modifiers. If the modifier is different, force to pay.

If the procedure code and the modifier are the same, deny the claim.

Exception: If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised March 31, 2005.</i>

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Suspend	Suspend	Deny
ECS	Suspend	Suspend	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Suspend	Suspend	Suspend	Deny
Special Batch	Suspend	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048,, Z5123 to Z5132, including modifiers.

For dates of service January 1, 2004 and after, same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for crosswalked procedure codes as noted below to replace codes X0001 to X3048, Z5123 to Z5132, including modifiers.

Local Code	Crosswalked Procedure Code
X3005	E0619 NU, E0619 RR
X3011	T2015 U7
X3012	H2023 U7
X3013	T2029 U7 NU

X3014	T2029 U7 RP
X3015	G0152 U7 UA
X3017	G0151 U7 UA
X3019	S5165 U7 NU, T2039 U7
X3020	S5165 U7 RP
X3028	T2003 U9
X3029	T2004 TT
X3030	T2001 TK
X3031	A0100 UA
X3032	A0100 UB
X3033	A0100 UC
X3034	A0100 UA TK
X3035	A0100 UA TT
X3036	A0100 UB TK
X3037	A0100 UB TT
X3038	A0100 UC TK
X3039	A0130 TK
X3040	H0031 HW
X3041	H0002
X3042	H0004 HW
X3044	H004 HW HR, H0004 HW HS
X3045	H0004 HW HQ
X3046	H2011 HW
X3047	H0033 HW
X3048	H2014 HW
Z5123	T2031 U7 U1
Z5124	T2031 U7 U2
Z5125	T2031 U7 U3
Z5128	S5140 U7 U1
Z5129	S5140 U7 U2
Z5130	S5140 U7 U3

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

Note: The allowed reimbursement amount for each provider should be the lesser of the RBRVS fee amount times .625 (62.5%), or the billed amount.

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Effective January 1, 2004 Waiver Codes T2021U7, T2021U7HQ, T2017U7, T2017U7TF, or T2017U7TG, submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

For dates of service January 1, 2004 and after, the procedure code for crosswalked procedure codes as noted below to replace codes Z5163, Z5164, Z5170, Z5171, and Z5172 submitted by different providers should be forced to pay. Procedure codes Z5173, Z5174, Z5175, and Z5176 are no longer covered by the IHCP effective July 1, 2003.

Local Code	Crosswalked Procedure Code
Z5163	T2021 U7
Z5164	T2021 U7 HQ
Z5170	T2017 U7
Z5171	T2017 U7 TF
Z5172	T2017 U7 TG

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

Effective January 1, 2004 Waiver codes T2004U7U1, T2004U7U3, T2004U7U4, T2004U7U6, T2004U7U8 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

For dates of service January 1, 2004 and after, for crosswalked procedure codes as noted below to replace codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay.

Local Code	Crosswalked Procedure Code
Z5195	T2004 U7 U1
Z5196	T2004 U7 U3
Z5197	T2004 U7 U4
Z5198	T2004 U7 U6
Z5199	T2004 U7 U8

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate claim/service.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

There are several methods of corrections that will pertain to the different claim types, please work appropriately.

NOTE: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017 and give the ICN to Team Lead.

Click on the related ICN(s) in the related history box.

If the related history ICN is the same as the suspended claim, Force to pay.

If the ICN is different click on the related ICN, compare the procedure code on the related ICN and the suspended claim. If the procedure is different, Force to pay.

If the procedure codes are the same and there is no modifier either on the suspended ICN or related ICN, Deny the claim.

If there is a modifier on the suspended claim or the related claim, look on the modifier sheet to see if the modifier is different. Force to pay. This usually happens on surgery codes which are the 10000-69999 series. Surgery procedures will usually have no modifiers at all and will not have AA or 80 modifiers either. When this claim bumps up against each other, force to pay, this usually happens on surgery codes which are the 10000-69999 series. Surgery procedures will usually have no modifiers of AA or 80. When these claims bump up against each other, force to pay.

Supply codes E1340, E1399 or B9999 look at billed amount if they are different. Force to pay.

If supply codes E1340, E1399, or B9999 that have the same dates of service and the same-billed amount, deny the claim.

Modifier 62:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two Surgeons) for the same recipient and on the same date of service, the audit can be forced for payment.

Case Management Claims:

There are new case management codes: G9012, H0004HW, H0004HW HS, H0004HR, H0004 U7, H0031HW, H0004HW HQ, H2011HW, H0033HW, H0035HW, T1016HW, 97535 HW HQ, 97537 HW HQ.

These codes have to be billed with the modifiers, which identifies them as PICs.

If the billing provider numbers are the same, look at the rendering provider number on both claims. If the rendering provider numbers are the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

(X3048-X3050), these codes should be Forced if the provider numbers are different, even if the procedure has the same modifier. These codes are not in effect after 1/1/04. The new case management codes are in effect 10/16/03.

If the billing provider numbers are the same, look at the rendering provider number on both claims. If the rendering provider number is the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Waiver Codes:**New Waiver Codes Effective 1/1/2004:**

H0032 U7 U1, T2015 U7, T2021 U7, T2021 U7 HQ, T2021U7 UA, T2021 U7 UA HQ, T2017 U7, T2017 U7 TF, T2017 U7 TG, T2004 U7 U1, T2004 U7 U3, T2004 U7 U4, T2004 U7 U6, T2004 U7 U8, T1016 U7, S5130 U7 UA, S5125 UA U7, S5150 U7 UA, T1005 U7 UA, S5125 U7 UA, T1016 U7, T2021 U7, T2021 U7 HQ, H0004 U7, S5150 U7 HQ.

If the billing provider numbers are the same, look at the rendering provider number on both claims. If the rendering provider number is the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Z5163, Z5164, Z5165, Z5166, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176, Z5190, Z5195, Z5196, Z5197, Z5198, Z5199, Z5202, Z5604, Z5701, Z5702, and Z5726, if submitted by different providers for the same date of service, cannot be used after 12/31/03.

If the billing provider numbers are the same, look at the rendering provider number on both claims. If the rendering provider number is the same, deny the claim. If the rendering provider numbers are different, force the claim to pay.

Modifier TC and 26:

If you have a procedure code billed with a 26 or TC modifier.

If the procedure code on one of the claims has a modifier of 26 and on the other claim, the procedure is billed with a TC modifier. Force the claim to pay.

If one claim has a procedure code with no modifier and the other claim has a procedure code with a 26 or TC modifier, deny the claim.

If the procedure code and the modifier is the same on both claims, deny the claim.

Remember the procedure code has to be the same on both claims.

Outpatient Claims:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017 and give the ICN to Team Lead.

Outpatient versus LTC:

- Click on the related ICN(s) in the related history box.
- Check to see if the revenue codes are different. If different revenue codes, force to pay.
- Check the revenue codes if the same revenue code is billed, and the procedure code is the same as well, deny the claim.
- *Exception:* If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Inpatient/X-Over Inpatient:

- Click on the related ICN(s) in the related history box.
- Check to see if the revenue codes are different. If the revenue codes are different., force to pay.
- If the date are overlapping, deny the claim.
- Check the revenue codes, if the same revenue code is billed and the procedure code is also the same, not different, deny the claim.
- If the revenue code is different, but, in the same revenue group and the procedure code is the same, deny the claim. *Example:* Suspended claim has 301-81000 and the claim in history has 307-81000.
- *Exception:* If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Ancillary Dupes:

If the ancillaries are already paid when a surgery code claim suspends:

- Force the duplicate audit.
- Write up an adjustment for the ancillary claim.
- Write the adjustment to recoup the dollar amount for the ancillary revenue code charges only.

If the surgery claim has already been paid and the claim with ancillary codes suspend, then:

- Deny the ancillary claim.
- Add the EOB 5012

Outpatient versus Home Health:

- Click on the related ICN (s) in the related history box.

- Check to see if the revenue codes are different. If different revenue code, force to pay. Check the revenue codes. If the same revenue code and procedure code are billed, not different, deny the claim.
- *Exception:* If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient versus Outpatient/X-over Outpatient:

- Click on the related ICN (s) in the related history box.
- If the dates are overlapping, deny the claim.
- If the related history ICN is the same as the suspended ICN, force to Pay.
- Look at the revenue code. If different., force to pay.
- If the revenue codes are the same, deny the claim.
- If the revenue codes are the same, but one claim has a procedure code, deny the claim.
- If revenue codes are the same, but the procedure code is different, force the claim to pay.
- If the revenue code is different, but in the same revenue group, and the procedure code is the same, deny the claim. *Example: Suspended claim has 301-81000 and the history claim has 307-81000.*
- *Exception:* If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Outpatient X-Overs versus Outpatient X-Overs:

- Click on the related history claim(s).
- Check the dates of service.
- Check the revenue/procedure codes.
- If the revenue codes are on both claims. Deny the claim.
- If the revenue codes are different, force to pay.
- If one of the claims has a procedure code with the revenue code, deny the claim.
- If a claim has the same revenue code, but, with different procedure codes, force the claim to pay.
- If the revenue code is different, but, in the same revenue group and the procedure code is the same, deny the claim. *Example: Suspended claim has 301- 81000, and the history claim has 307-81000.*
- *Exception:* If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

LTC Claims:

Note: If the related ICN is a Shadow or Encounter Claim (Region 22), deny the claim with EOB 2017 and give the ICN to Team Lead.

LTC versus LTC:

- Check the dates of service
- If the date of service is a continuation. (Remember a continuation is where the to date on one claim is the from date on the other claim.
- Look at the patient status code. If the status code states that the recipient was discharged or transferred, force the claim to pay.
- If the status code is 30 on both claims, deny the claim.
- If the dates of service are overlapping:
 - Look at the revenue codes.
 - If different revenue codes, force the claim to pay.
 - If the revenue codes are the same, deny the claim.
- If the related history ICN is the same as the suspended ICN, force to pay.
- **Exception:** If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

One bed rate revenue codes: 100-179, 200-219, and 230-239. These revenue codes cannot be billed on the same dates of service. You cannot be in two beds at the same time. Exception: If one of the claims is a long-term care claim, and the provider is billing leave days (180-185), then the claim can be forced.

LTC versus Inpatient/X-Over Inpatient:

- Click on the related history claim(s).
- Check dates of service.
- If the dates of service look like a continuation, (if the last date of service is the beginning date of the other claim), then force to pay.
- If the dates of service are the same and the revenue codes are different and they are not the bed revenue codes (look at the list below for bed revenue codes), force the claim to pay.
- If the current claim and the related claim(s) has the bed revenue code. Check to see if there are leave day revenue codes (180-185) billed on the LTC claim. If the leave days equal or exceed the days for the hospital claim, force to pay.
- If no leave days are on the LTC claim, and the dates of service are the same as the hospital claim with the same revenue codes, deny the claim.
- If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days of the hospital stay.

- **Exception:** If the revenue code is 250, which is drug supply), look at the billed amount, if they are the same, deny the claim. If the billed amount is different on revenue code 250, Force to pay.

NOTE: Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claims have four days, the leave days on the LTC claim, must equal four or more units, force to pay.

On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time. Exception: If one of the claims is a long-term care claim and the provider is billing leave days.

HOME HEALTH:

- **Note:** If the related ICN is a Shadow or Encounter Claim (Region 22), then deny the claim with EOB 2017 and give the ICN to the Team Lead.

Home Health versus Home Health/Outpatient:

- Click on the related ICN(s) in the related history box.
- If the related ICN is the same as the suspended ICN, force to pay.
- Check to see if the revenue codes are different. If different revenue codes, force to pay.
- Check the revenue codes, if the same revenue code, check to see if there is a procedure code. If the procedure code is different, force to pay.
- If the revenue code is the same and the procedure code is the same. Check to see if the procedure code is billed with modifiers. If the modifier is different, force to pay.
- If the procedure code and the modifier are the same, deny the claim.
- **Exception:** If the revenue code is 250, which is drug supply, look at the billed amount. If they are the same, deny the claim. If the billed amount is different on revenue code 250, force to pay.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised August 31, 2004.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Suspend	Suspend	Deny
ECS	Suspend	Suspend	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Pay	Pay	Suspend	Deny
Special Batch	Suspend	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle. Fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048,, Z5123 to Z5132, including modifiers.

For dates of service January 1, 2004 and after, same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for crosswalked procedure codes as noted below to replace codes X0001 to X3048, Z5123 to Z5132, including modifiers.

Local Code	Crosswalked Procedure Code
X3005	E0619 NU, E0619 RR
X3011	T2015 U7
X3012	H2023 U7
X3013	T2029 U7 NU

X3014	T2029 U7 RP
X3015	G0152 U7 UA
X3017	G0151 U7 UA
X3019	S5165 U7 NU, T2039 U7
X3020	S5165 U7 RP
X3028	T2003 U9
X3029	T2004 TT
X3030	T2001 TK
X3031	A0100 UA
X3032	A0100 UB
X3033	A0100 UC
X3034	A0100 UA TK
X3035	A0100 UA TT
X3036	A0100 UB TK
X3037	A0100 UB TT
X3038	A0100 UC TK
X3039	A0130 TK
X3040	H0031 HW
X3041	H0002
X3042	H0004 HW
X3044	H004 HW HR, H0004 HW HS
X3045	H0004 HW HQ
X3046	H2011 HW
X3047	H0033 HW
X3048	H2014 HW
Z5123	T2031 U7 U1
Z5124	T2031 U7 U2
Z5125	T2031 U7 U3
Z5128	S5140 U7 U1
Z5129	S5140 U7 U2
Z5130	S5140 U7 U3

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

Note: The allowed reimbursement amount for each provider should be the lesser of the RBRVS fee amount times .625 (62.5%), or the billed amount.

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Effective January 1, 2004 Waiver Codes T2021U7, T2021U7HQ, T2017U7, T2017U7TF, or T2017U7TG, submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

For dates of service January 1, 2004 and after, the procedure code for crosswalked procedure codes as noted below to replace codes Z5163, Z5164, Z5170, Z5171, and Z5172 submitted by different providers should be forced to pay. Procedure codes Z5173, Z5174, Z5175, and Z5176 are no longer covered by the IHCP effective July 1, 2003.

Local Code	Crosswalked Procedure Code
Z5163	T2021 U7
Z5164	T2021 U7 HQ
Z5170	T2017 U7
Z5171	T2017 U7 TF
Z5172	T2017 U7 TG

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

Effective January 1, 2004 Waiver codes T2004U7U1, T2004U7U3, T2004U7U4, T2004U7U6, T2004U7U8 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

For dates of service January 1, 2004 and after, for crosswalked procedure codes as noted below to replace codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay.

Local Code	Crosswalked Procedure Code
Z5195	T2004 U7 U1
Z5196	T2004 U7 U3
Z5197	T2004 U7 U4
Z5198	T2004 U7 U6
Z5199	T2004 U7 U8

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate claim/service.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised April 1, 2004.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Suspend	Suspend	Deny
ECS	Suspend	Deny	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Pay	Pay	Suspend	Deny
Special Batch	Suspend	Deny	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the <u>lesser</u> the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Outpatient X-Over claims:

Since, we now edit at the detail for x-over claims, the OMPP has asked that claims hitting audit 5000, suspend, rather than deny, and allow the reso clerk to verify if the detail should be forced or denied. The system will only look at the first 3 digits of the procedure code, the reso staff should verify the remaining and determine the proper method of correction.

This audit will be monitored to determine how many suspended claims changing this from deny to suspend has created.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, **Z5165, Z5166**, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176 and 5726 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

If a claim billing case management codes: Z5202, Z5701, Z5702, or Z5190 is received and hits this edit, it can be forced to pay if the billing provider number is the same but the referring and/or rendering provider numbers are different.

EOB Code

5000 – This is a duplicate of another claim.

5012 - Ancillary charges are not reimbursable on an Outpatient claim, when a surgical procedure is paid by ASC pricing. All charges are inclusive in the ASC payment.

ARC Code

18 – Duplicate claim/service

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.

- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

**Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.

Method of Correction for EOB 5012

If ancillaries are already paid when a surgery code claim suspends:

- Force duplicate audit
- Write down ICN related to the ancillary claim and give to Team Lead
- Team Lead will write up an adjustment to recoup any dollars reimbursed for the ancillary charges.

If the surgery has already been paid and the claim with ancillary codes suspends:

- Deny ancillary services and add EOB 5012

This is effective 7/25/03 and this is a work around until CSR is completed. CSR was submitted on 7/23/03.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised August 28, 2003.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Deny	Suspend	Deny
ECS	Suspend	Deny	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Pay	Pay	Suspend	Deny
Special Batch	Suspend	Deny	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, same first three digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, Z5176 and **5726** submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

If a claim billing case management codes: Z5202, Z5701, Z5702, or Z5190 is received and hits this edit, it can be forced to pay if the billing provider number is the same but the referring and/or rendering provider numbers are different.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

****Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.**

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised July 23, 2003.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Deny	Suspend	Deny
ECS	Suspend	Deny	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Pay	Pay	Suspend	Deny
Special Batch	Suspend	Deny	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same first three** digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002. Effective May 5, 2003, procedure code Z5604 should be included in this process. **Effective January 1, 2003, waiver code Z5726 needs to be forced.**

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

EOB Code

5000 – This is a duplicate of another claim.

5012 – Ancillary charges are not reimbursable on an outpatient claim when a surgical procedure is paid by Ambulatory Surgery Center (ASC) pricing. All charges are inclusive in the ASC payment.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
 - If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
 - If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
 - Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
 - Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
 - Deny the claim if waiver claims with the same procedure code are from the same provider.
- ** Partially paid claims associated with \$9,999.99 should be fully recouped and the claim should be broken down as a new day claim.

Method of Correction for EOB 5012

- **If ancillaries are already paid when a surgery code claim suspends:**
 - Force duplicate audit
 - Write down the internal control number (ICN) related to the ancillary claim and give to the team lead
 - Team lead will write up an adjustment to recoup any dollars reimbursed for the ancillary charges
- **If the surgery has been paid and the claim with ancillary code suspends: Deny ancillary services and add EOB 5012.**

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised June 16, 2003.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, I, M, O	C	L	P, Q
Paper Claim	Suspend	Deny	Suspend	Deny
ECS	Suspend	Deny	Suspend	Deny
Shadow	Pay	Pay	Pay	Deny
POS	Suspend	Deny	Suspend	Deny
Adjustments	Pay	Pay	Suspend	Deny
Special Batch	Suspend	Deny	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same first three** digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

Waiver codes Z5195, Z5196, Z5197, Z5198, and Z5199 that are submitted by the same or different providers should be forced to pay. Effective date for this change is July 1, 2003, with dates of service starting July 1, 2003.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised May 7, 2003.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, M, O, P, Q	C	L
Paper Claim	Suspend	Deny	Suspend
ECS	Suspend	Deny	Suspend
Shadow	Pay	Pay	Pay
POS	Suspend	Deny	Suspend
Adjustments	Pay	Pay	Suspend
Special Batch	Suspend	Deny	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same first three** digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002. **Effective May 5, 2003, procedure code Z5604 should be included in the process.**

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised January 10, 2003.</i>

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, M, O, P, Q	C	L
Paper Claim	Suspend	Deny	Suspend
ECS	Suspend	Deny	Suspend
Shadow	Pay	Pay	Pay
POS	Suspend	Deny	Suspend
Adjustments	Pay	Pay	Suspend
Special Batch	Suspend	Deny	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same first three** digits of the procedure code, same member number, same dates of service, and same tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to *Appendix A*) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to *Appendix A*) will bypass dupe audits 5000, 5001, 5010, and 5011.

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.
- Deny the claim if waiver claims with the same procedure code are from the same provider.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised August 19, 2002.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, M, O, P, Q	C	L
Paper Claim	Suspend	Deny	Suspend
ECS	Suspend	Deny	Suspend
Shadow	Pay	Pay	Pay
POS	Suspend	Deny	Suspend
Adjustments	Pay	Pay	Suspend
Special Batch	Suspend	Deny	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. If both claims have a modifier of 62, the audit can be forced for payment.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

Compare detail with history detail and determine if the details are the same. If the claim being submitted has the same rendering provider number, **same** first **three** digits of the procedure code, **same** member number, **same** dates of service, and **same** tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay, **suspend the claim. Dental claim details that meet the above criteria, but the procedure coded billed is listed on procedure group 136, 137, 138, or 139, (refer to Appendix A) will bypass this audit and deny for audit 5011. Procedure codes listed on procedure group 142 (refer to Appendix A) will bypass dupe audits 5000, 5001, 5010, and 5011.**

Waiver Claims

Waiver Codes Z5163, Z5164, Z5170, Z5171, Z5172, Z5173, Z5174, Z5175, or Z5176 submitted by different providers should be forced to pay. The effective date of change is August 1, 2002, for dates of service beginning July 1, 2002.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
 - If the claims are not duplicates, override the audit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.
- **Force the claim to pay if waiver claims billed with the procedure codes listed above, but are from different providers.**
- **Deny the claim if waiver claims with the same procedure code are from the same provider.**

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised April 5, 2002.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, M, O, P, Q	C	L
Paper Claim	Suspend	Deny	Suspend
ECS	Suspend	Deny	Suspend
Shadow	Pay	Pay	Pay
POS	Suspend	Deny	N/A
Adjustments	Pay	Pay	Suspend
Special Batch	Suspend	Deny	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, Z5123 to Z5132, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit. **If both claims have a modifier of 62, the audit can be forced for payment.**

<i>Note: The allowed reimbursement amount for each provider should be the <u>lesser</u> the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

The claim being submitted has the same rendering provider number, first five digits of the procedure code, recipient number, dates of service, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
- If the claims are not duplicates, override the audit.
- **Partially paid claims associated with \$9,999.99 should be fully recouped and the claim needs to be broken down as a new day claim.**

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised June 27, 2001.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, D, H, M, O, P, Q	C	L
Paper Claim	Suspend	Deny	Suspend
ECS	Suspend	Deny	Suspend
Shadow	Pay	Pay	Pay
POS	Suspend	Deny	N/A
Adjustments	Pay	Pay	Suspend
Special Batch	Suspend	Deny	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, **Z5123 to Z5132**, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

The claim being submitted has the same rendering provider number, first five digits of the procedure code, recipient number, dates of service, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.

- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
- If the claims are not duplicates, override the audit.

Audit: ESC 5000 Possible Duplicate

<i>Note: Audit 5000 revised January 5, 2000.</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	D, H, M, O, P, Q	L
Paper Claim	Suspend	Suspend
ECS	Suspend	Suspend
Shadow	Pay	Pay
POS	Suspend	N/A
Adjustments	Pay	Suspend
Special Batch	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, including modifiers.

Exception:

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two surgeons), for the same recipient, on the same date of service, and one of the providers has already been paid, calculate the Medicaid allowed amount for the second provider by multiplying the RBRVS fee amount times .625 (62.5%) and override the audit.

<i>Note: The allowed reimbursement amount for each provider should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.</i>
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Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

Inpatient and LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

The claim being submitted has the same rendering provider number, first five digits of the procedure code, recipient number, dates of service, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.

- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
- If the claims are not duplicates, override the audit.

Audit: ESC 5000 Possible Duplicate

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	D, H, M, O, P, Q	L
Paper Claim	Suspend	Suspend
ECS	Suspend	Suspend
Shadow	Pay	Pay
POS	Suspend	N/A
Adjustments	Pay	Suspend
Special Batch	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims history and other claims being processed in the same cycle, fail this audit if another claim is found with the following matches:

Medical Claims

Same rendering provider number, recipient number, overlapping dates of service, and same all three digits of the procedure code for procedure codes 10000 through 99999, J0000 to J9999, X0001 to X3048, including modifiers.

Transportation, Medical Supplies Claims

Claims – Same billing provider number, recipient number, overlapping dates of service, and same first five digits of the procedure code including modifier.

Pharmacy Claims

Same recipient number, same date of service, and same first nine digits of the NDC number.

LTC Claims

The claim being submitted has the same billing provider, same recipient number, same or overlapping dates of service, and same revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and if the procedure codes are between the range 10000-69999 or 80002-83399, the first three digits are the same. If not one of the codes in the range above, the system looks for all five digits of the procedure code to be the same. If billed with a revenue code and the revenue code has a corresponding HCPCS code, then audit for same recipient number, same or overlapping dates of service, same revenue code, and same all five digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. If billed with a revenue code only, the system looks for the same revenue code as well as same provider, same recipient number, same or overlapping dates of service. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same provider, same recipient number, same or overlapping dates of service, and same first three digits of the procedure code as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the audit if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental Claims

The claim being submitted has the same rendering provider number, first five digits of the procedure code, recipient number, dates of service, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors found, compare current claim with history claim and determine if the claims are the same, or in the case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim. If the claim is for home health services, override the audit if the claims duplicating are on the same claim form (same 12 digits of the ICNs).
- If a duplication exists, deny the claim.
- If the claims are not duplicates, override the audit.

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised March 31, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Deny
ECS	Deny	Deny	Deny
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Deny
Adjustments	Deny	Deny	Deny
Special Batch	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Inpatient and Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

For nursing home claims billed with revenue codes 110, 120, 130, 180, 183, or 185, the system will compare the current claim to a hospice claim paid in the history file or another hospice claim in the same cycle approved to pay with one of the following revenue codes: 180, 183, 185, 652, 654, or 659. The system looks for claims with the same dates of service and patient identification.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

For hospice claims billed with revenue codes 180, 183, 185, 652, 654, or 659, the system will compare the current claim to a long term care (LTC) claim paid in the history file or another LTC claim in the same cycle approved to pay with one of the following revenue codes: 110, 120, 130, 180, 183, or 185. The system looks for claims with the same dates of service and patient identification.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.

EOB Code

5001 – This is a duplicate of another claim.

5012 – Ancillary charges are not reimbursable on an outpatient claim when a surgical procedure is paid by ASC pricing. All charges are inclusive in the ASC payment.

Method of Correction

- Claim Type (D)

- Claims failing this audit systematically deny.
- Claim Type (Q)
 - Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Special Batches

- Claims are submitted to the Claims Quality Analyst or Resolutions team lead. These claims are broken down into multiple lines by:
 - Taking the total amount billed and dividing into separate claims that don't exceed the \$9,999.99 amount.
 - Once the region 90 claims suspend, force the edit if the claims are within the same batch.
 - If the duplicate claims do not fall within the same batch as the original claim, deny the edit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim will need to be broken down as a new day claim.
- If the billed amount is higher than the average claim submitted by the provider, the EDS Pharmacy Unit is notified and consulted for clarification of an increase in billing.

Method of Correction for EOB 5012

- If ancillaries are paid when a surgery code claim suspends
 - Force duplicate audit
 - Write down the ICN related to the ancillary claim and give it to the team lead
 - The team lead will write up an adjustment to recoup any dollars reimbursed for the ancillary charges
- If the surgery has been paid and the claim with ancillary codes suspends:
 - Deny ancillary services and add EOB 5012.

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised July 23, 2003.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Deny
ECS	Deny	Deny	Deny
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Deny
Adjustments	Deny	Suspend	Deny
Special Batch	Suspend	Suspend	Deny

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Inpatient and Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

For nursing home claims billed with revenue codes 110, 120, 130, 180, 183, or 185, the system will compare the current claim to a hospice claim paid in the history file or another hospice claim in the same cycle approved to pay with one of the following revenue codes: 180, 183, 185, 652, 654, or 659. The system looks for claims with the same dates of service and patient identification.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

For hospice claims billed with revenue codes 180, 183, 185, 652, 654, or 659, the system will compare the current claim to a long term care (LTC) claim paid in the history file or another LTC claim in the same cycle approved to pay with one of the following revenue codes: 110, 120, 130, 180, 183, or 185. The system looks for claims with the same dates of service and patient identification.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.

EOB Code

5001 – This is a duplicate of another claim.

5012 – Ancillary charges are not reimbursable on an outpatient claim when a surgical procedure is paid by ASC pricing. All charges are inclusive in the ASC payment.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically deny.
- Claim Type (Q)
 - Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Special Batches

- Claims are submitted to the Claims Quality Analyst or Resolutions team lead. These claims are broken down into multiple lines by:
 - Taking the total amount billed and dividing into separate claims that don't exceed the \$9,999.99 amount.
 - Once the region 90 claims suspend, force the edit if the claims are within the same batch.
 - If the duplicate claims do not fall within the same batch as the original claim, deny the edit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim will need to be broken down as a new day claim.
- If the billed amount is higher than the average claim submitted by the provider, the EDS Pharmacy Unit is notified and consulted for clarification of an increase in billing.

Method of Correction for EOB 5012

- **If ancillaries are paid when a surgery code claim suspends**
 - **Force duplicate audit**
 - **Write down the ICN related to the ancillary claim and give it to the team lead**
 - **The team lead will write up an adjustment to recoup any dollars reimbursed for the ancillary charges**
- **If the surgery has been paid and the claim with ancillary codes suspends:**
 - **Deny ancillary services and add EOB 5012**

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised January 10, 2003.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B,C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Suspend
ECS	Deny	Deny	Suspend
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Suspend
Adjustments	Deny	Suspend	Suspend
Special Batch	Suspend	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Inpatient and Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

For nursing home claims billed with revenue codes 110, 120, 130, 180, 183, or 185, the system will compare the current claim to a hospice claim paid in the history file or another hospice claim in the same cycle approved to pay with one of the following revenue codes: 180, 183, 185, 652, 654, or 659. The system looks for claims with the same dates of service and patient identification.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

For hospice claims billed with revenue codes 180, 183, 185, 652, 654, or 659, the system will compare the current claim to a long term care (LTC) claim paid in the history file or another LTC claim in the same cycle approved to pay with one of the following revenue codes: 110, 120, 130, 180, 183, or 185. The system looks for claims with the same dates of service and patient identification.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.

EOB Code

5001 – This is a duplicate of another claim.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically deny.

- Claim Type (Q)
 - Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Special Batches

- Claims are submitted to the Claims Quality Analyst or Resolutions team lead. These claims are broken down into multiple lines by:
 - Taking the total amount billed and dividing into separate claims that don't exceed the \$9,999.99 amount.
 - Once the region 90 claims suspend, force the edit if the claims are within the same batch.
 - If the duplicate claims do not fall within the same batch as the original claim, deny the edit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim will need to be broken down as a new day claim.
- If the billed amount is higher than the average claim submitted by the provider, the EDS Pharmacy Unit is notified and consulted for clarification of an increase in billing.

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised June 24, 2002.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Suspend
ECS	Deny	Deny	Suspend
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Suspend
Adjustments	Deny	Suspend	Suspend
Special Batch	Suspend	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Inpatient and Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

For nursing home claims billed with revenue codes 110, 120, 130, 180, 183, or 185, the system will compare the current claim to a hospice claim paid in the history file or another hospice claim in the same cycle approved to pay with one of the following revenue codes: 180, 183, 185, 652, 654, or 659. The system looks for claims with the same dates of service and patient identification.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

For hospice claims billed with revenue codes 180, 183, 185, 652, 654, or 659, the system will compare the current claim to a long term care (LTC) claim paid in the history file or another LTC claim in the same cycle approved to pay with one of the following revenue codes: 110, 120, 130, 180, 183, or 185. The system looks for claims with the same dates of service and patient identification.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.

EOB Code

5001 – This is a duplicate of another claim.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically deny.
- Claim Type (Q)

- Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Special Batches

- Claims are submitted to the Claims Quality Analyst or Resolutions team lead. These claims are broken down into multiple lines by:
 - Taking the total amount billed and dividing into separate claims that don't exceed the \$9,999.99 amount.
 - Once the region 90 claims suspend, force the edit if the claims are within the same batch.
 - If the duplicate claims do not fall within the same batch as the original claim, deny the edit.
- Partially paid claims associated with \$9,999.99 should be fully recouped and the claim will need to be broken down as a new day claim.
- If the billed amount is higher than the average claim submitted by the provider, the EDS Pharmacy Unit is notified and consulted for clarification of an increase in billing.

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised April 5, 2002.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Suspend
ECS	Deny	Deny	Suspend
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Suspend
Adjustments	Deny	Suspend	Suspend
Special Batch	Suspend	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Inpatient and Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

For nursing home claims billed with revenue codes 110, 120, 130, 180, 183, or 185, the system will compare the current claim to a hospice claim paid in the history file or another hospice claim in the same cycle approved to pay with one of the following revenue codes: 180, 183, 185, 652, 654, or 659. The system looks for claims with the same dates of service and patient identification.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

For hospice claims billed with revenue codes 180, 183, 185, 652, 654, or 659, the system will compare the current claim to a long term care (LTC) claim paid in the history file or another LTC claim in the same cycle approved to pay with one of the following revenue codes: 110, 120, 130, 180, 183, or 185. The system looks for claims with the same dates of service and patient identification.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.

EOB Code

5001 – This is a duplicate of another claim.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically deny.
- Claim Type (Q)

- Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Special Batches

- **Claims are submitted to the Claims Quality Analyst or Resolution's team lead. These claims are broken down into multiple lines by:**
 - Taking a total amount billed and dividing into separate claims that don't exceed the \$9,999.99 amount.
 - Once the region 90 claims suspend, force the edit if the claims are within the same batch.
 - If the duplicate claims do not fall within the same batch as the original claim, deny the edit.
- **Partially paid claims associated with \$9,999.99 should be fully recouped and the claim will need to be broken down as a new day claim.**

Audit: ESC 5001 Exact Duplicate*Note: Edit 5001 revised August 16, 2001.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, D, H, I, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, D, H, I, M, O	L	P, Q
Paper Claim	Deny	Deny	Suspend
ECS	Deny	Deny	Suspend
Shadow	Deny	Deny	Deny
POS	Deny	Deny	Suspend
Adjustments	Deny	Suspend	Suspend
Special Batch	Suspend	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay. **Dental claim details that meet the above mentioned criteria, but the procedure code billed is listed on procedure group 136, 137, 138, or 139 (refer to Appendix A) will bypass this audit and suspend for audit 5010.**

EOB Code

5001 – This is a duplicate of another claim.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically **deny**.
- Claim Type (Q)
 - Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (A, B, C, H, I, L, M, O, P)
 - Claims failing this audit systematically deny.

Audit: ESC 5001 Exact Duplicate

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, L, M, O, P, Q	20	All	Detail	Yes	Yes	0

Disposition	H, M, O, P	D	L	Q
Paper Claim	Deny	Pay	Deny	Suspend
ECS	Deny	Pay	Deny	Suspend
Shadow	Deny	Deny	Deny	Deny
POS	Deny	N/A	N/A	N/A
Adjustments	Deny	Pay	Suspend	Suspend
Special Batch	Suspend	Pay	Suspend	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

If the following conditions apply, fail the audit with EOB 5001:

Medical Claims

The claim being submitted has the same rendering provider number, recipient number, dates of service, procedure code, and modifier as a paid claim in the history file or another claim in the same cycle that has been approved to pay except for the following procedure code: Y4009.

Pharmacy Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Compound Drug Claims

The claim being submitted has the same billing provider number, recipient number, date of service, and NDC(s) as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Nursing Home Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and revenue codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

Outpatient Claims

The claim being submitted has the same billing provider number, recipient number, dates of service, and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not dupe against system-generated details.

Home Health Claims

The claim being submitted has the same billing provider number, recipient number, dates of service and HCPCS codes as a paid claim in the history file or another claim in the same cycle that has been approved to pay. Do not fail the claim if the duplicated claim is on the same claim form (identical first 12 digits of the ICNs).

For hospice claims being billed on the home health claim form, the system will compare the current claim to a history claim for a revenue code when a procedure code is not present. In this instance the system will need to view a claim on the same claim form.

Dental claims

The claim being submitted has the same billing provider number, recipient number, dates of service, procedure code, and tooth number as a paid claim in the history file or another claim in the same cycle that has been approved to pay.

EOB Code

5001 – This is a duplicate of another claim.

Method of Correction

- Claim Type (D)
 - Claims failing this audit systematically pay.
- Claim Type (Q)
 - Compare claim to suspense screen and correct any keying errors. If no keying errors, compare the claim being submitted to claim paid in history. If **all** of the NDCs on both claims match, deny the claim with EOB 5001. If **all** the NDCs on both claims do not match, override the audit and pay the claim.
- Claim Type (H, L, M, O, P)
 - Claims failing this audit systematically deny.

Audit: ESC 5002 Duplicate of Previous Adjustment

<i>Note: Edit 5002 revised August 31, 2004.</i>

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All Claim Types Inactive	20	All	Detail	Yes	Yes	0

Disposition	All Claim Types Inactive
Paper Claim	N/A
ECS	N/A
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	N/A

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim is processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5002.

Inpatient and Nursing Home claims

The claim being submitted has the same recipient number and the same or overlapping dates of service as a paid claim in the history file or another claim the same cycle that has been approved to pay.

EOB Code

5002 – This adjustment is a duplicate of a previous adjustment.

ARC Code

18 – Duplicate claim/service.

Method of Correction

N/A.

Audit: ESC 5002 Duplicate of Previous Adjustment

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All Claim Types Inactive	20	All	Detail	Yes	Yes	0

Disposition	All Claim Types Inactive
Paper Claim	N/A
ECS	N/A
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	N/A

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim is processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5002.

Inpatient and Nursing Home claims

The claim being submitted has the same recipient number and the same or overlapping dates of service as a paid claim in the history file or another claim the same cycle that has been approved to pay.

EOB Code

5002 – This adjustment is a duplicate of a previous adjustment.

Method of Correction

N/A

Audit: ESC 5003 Possible POS Reversal Duplicate*Note: Edit 5003 revised August 31, 2004.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P	20	All	Detail	No	No	0

Disposition	P
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a POS pharmacy claim(s) on the history file that has previously been reversed.

Audit Criteria

Compare the reversal being processed with reversals already processed in the history or other reversals being processed in the same cycle, if another reversal is found with the following matches, fail this audit with EOB 5003.

Pharmacy Claim Reversal

If the provider number, date filled, and prescription number match a claim that has already been reversed, then set this audit.

EOB Code

5003 – This is a duplicate of another claim reversal.

ARC Code

18 – Duplicate claim/service.

Method of Correction

Claims failing this audit systematically deny.

Audit: ESC 5003 Possible POS Reversal Duplicate

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P	20	All	Detail	No	No	0

Disposition	P
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the claim being processed is a possible duplicate of a POS pharmacy claim(s) on the history file that has previously been reversed.

Audit Criteria

Compare the reversal being processed with reversals already processed in the history or other reversals being processed in the same cycle, if another reversal is found with the following matches, fail this audit with EOB 5003.

Pharmacy Claim Reversal

If the provider number, date filled, and prescription number match a claim that has already been reversed, then set this audit.

EOB Code

5003 – This is a duplicate of another claim reversal.

Method of Correction

- Claims failing this audit systematically deny.
- Submit manual adjustment.

Audit: ESC 5004 Reversal Not Processed No Match Found

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	66	All	Header	No	No	0

Disposition	All
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Note: This audit has been removed from the Jackson and is no longer active.

Audit Description**Audit Criteria****EOB Code**

5004 – Reversal not processed, no match found on RX number and provider number.
Please refer to your POS manual.

Method of Correction

N/A

Audit: ESC 5006 POS Reversal Claim Over 60 Days

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	66	All	Header	No	No	0

Disposition	All
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

Note: This audit has been removed from the Jackson and is no longer active.

Audit Description**Audit Criteria****EOB Code**

5006 – Reversal not processed, claim over 60 days – submit manual adjustment.

Method of Correction

N/A

Audit: ESC 5007 Exact Duplicate Header*Note: Audit 5007 revised August 31, 2004*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Header	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5007.

All Crossover Claims

The claim being submitted has the same recipient and provider number, same date of service, and same co-insurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient and provider number, and same from and through date of service as a paid claim in history or a claim that has been approved to pay.

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

EOB Code

5007 – This is a duplicate of another claim. If this claim was intended to be an adjustment, please submit the appropriate adjustment request form.

ARC Code

18 – Duplicate claim/service.

Method of Correction

- **Claims failing this audit will systematically deny.**
- Region 90 claims (special batch) will suspend so that, per the State's instructions, they can be forced to pay.

Audit: ESC 5007 Exact Duplicate Header*Note: Audit 5007 revised January 10, 2003*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Header	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5007.

All Crossover Claims

The claim being submitted has the same recipient and provider number, same date of service, and same co-insurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient and provider number, and same from and through date of service as a paid claim in history or a claim that has been approved to pay.

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

EOB Code

5007 – This is a duplicate of another claim. If this claim was intended to be an adjustment, please submit the appropriate adjustment request form.

Method of Correction

- Claims failing this audit systematically deny.
- Region 90 claims (special batch) will suspend so that, per the State's instructions, they can be forced to pay.

Audit: ESC 5007 Exact Duplicate Header

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Header	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5007.

All Crossover Claims

The claim being submitted has the same recipient and provider number, same date of service, and same co-insurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient and provider number, and same from and through date of service as a paid claim in history or a claim that has been approved to pay.

EOB Code

5007 – This is a duplicate of another claim. If this claim was intended to be an adjustment, please submit the appropriate adjustment request form.

Method of Correction

- Claims failing this audit systematically deny.
- Region 90 claims (special batch) will suspend so that, per the State's instructions, they can be forced to pay.

Audit: ESC 5008 Suspect Duplicate Header*Note: Edit 5008 revised March 31, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit.

All Crossovers**Case 1**

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Case 2

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient number and same or overlapping dates of service as a paid claim in history or a claim that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate/Claim service.

Method of Correction

There are several different methods of correction listed below by specific claim type, please use the properly identified claim type and make correction.

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors are found, compare current claim with history claim and determine if the claims are the same, or in case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim.
- In Cases 1 and 2, if the history claim is a LTC claim, check to make sure that the LTC claim was billed with a room revenue code (for example, 120) or a leave day code (180). If the LTC claim was billed with either of these revenue codes and the current claim was not, then override the audit.
- If an inpatient (or inpatient crossover) claim dupes against an outpatient (or outpatient crossover) or a home health claim, then override the audit.
- If duplication exists, deny the claim.
- If no duplication exists, override the error.

Note: In the Related History window, these claims will show up as duplicating off of a detail. Ignore this and work the claim as normal. The system cannot list the related history as a header, even though in the dupe logic it is looking at the header.

Note: If the Related ICN is a Shadow or Encounter Claim (region 22), deny the claim, add EOB 2018 and give the ICN to Carolyn McClain.

X-Over Physician Claims:

- Click on the related ICN(s) in the related history box.
- If the procedure codes are the same, deny the claim
- If the procedure code has a modifier and they are different modifiers, force to pay
- If the current procedure code is the same procedure as in the history ICN(s), deny the claim

Modifier TC and 26:

- If the procedure code on one claim has a modifier of 26 and on the other claim it has a TC. force the claim to pay.
- If one claim has a procedure code with no modifier and the other claim has a procedure code with a 26 or TC modifier. Deny the claim.
- If the procedure code and the modifier are the same on both claims. deny the claim.
- *Remember the procedure code has to be the same on both claims*

Modifier 62

If two different providers bill the same surgical procedure (10000-69999) with a 62 modifier (two Surgeons), for the same recipient and on the same date of service, the audit can be forced for payment.

Inpatient:

Note: If the related ICN is a Shadow or Encounter claim (region 22), deny the claim, add EOB 2018 and give the ICN to Carolyn McClain.

Mental Health Providers are allowed to bill leave days, effective 1/1/05

Ancillary Dupes:

If the ancillaries are already paid when a surgery code claim suspends

- Force the duplicate audit.
- Write up an adjustment for the ancillary claim.
- Write the adjustment to recoup the dollar amount for the ancillary revenue code charges only.

If the surgery claim has already been paid and the claim with ancillary codes suspend,

- Deny the ancillary claim.
- Add the EOB 5012.

Inpatient Versus Outpatient/X-Over Outpatient:

- Click on the relate history claim(s).
- Check the revenue/procedure codes. If the revenue codes are on both claims without a different procedure code, deny the claim.
- If the revenue codes are the same and has a procedure code or a different procedure code, force claim to pay.
- If the revenue codes are different, force the claim to pay.

On bed rate revenue codes, 100-179, 200-219, and 230-239, you cannot be in two beds at one time. Exception: If one of the claims is a long term care claim (L) and the provider is billing for leave days (180-185 rev. codes), force to pay. If revenue code 250 (drug, supply) is billed, look at the billed amount , if they are

the same, deny the claims. If the billed amount is different on revenue code 250, force to pay.

Inpatient versus LTC:

- Click on the related history claim(s).
- Check dates of service.
- If the dates of service look like a continuation, (if the last date of service is the beginning date of the other claim), force to pay.
- If the dates of service are the same and the revenue codes are different, and they are not the bed revenue codes, (look at the list above for bed revenue codes), force to pay.
- If the current claim and the related claim(s) has the bed revenue code, check to see if there are leave days on the LTC (L) claim. If the leave days equal or exceed the days for the hospital claim, force to pay.
- If no leave days are on the LTC claim and the dates of service are the same as the hospital with the same revenue codes, deny the claim.
- If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days for the hospital stay.
- Exception: If the revenue code is 250 (drug, supply) look at the billed amount, if they are the same deny the claim. If the billed amount is different for revenue code 250, force to pay.

NOTE:

Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claim has four days, then the LTC claim must have four days for leave days and no more, force to pay.

On bed rate revenue codes, 100-179, 200-219, and 230-239 you cannot be in two beds at one time. Exception: If one claim is a LTC claim and the provider is billing leave days.

Inpatient Vs Inpatient:

- Click on the related history claim(s).
- Check the dates of service.
- If the dates of service is a continuation, force to pay.
- If the dates of service is overlapping, deny the claim.
- If the date of service is the same, deny the claim.
- Exception: If the revenue code is 250 (drug, supply) look at the billed amount, if they are the same deny the claim. If the billed amount is different for revenue code 250, force to pay.

On bed rate code 100-179, 200-219, and 230-239, you cannot be in two beds at one time.

Inpatient Xover versus LTC:

- Click on the related history claim (s).
- Check dates of service.
- If the dates of service look like a continuation, (if the last date of service, is the beginning date of the other claim), force to pay.
- If the dates of service are the same and the revenue codes are different and they are not the bed revenue codes, (look at the list above for the bed revenue codes), force the claim to pay.
- If the current claim and the related claim(s) has the bed revenue code. Check to see if there are leave days on the LTC claim. If the leave days, equal or exceed the days for the hospital claim, force to pay.
- If no leave days are on the LTC claim and the date of service is the same as the hospital with the same revenue code, deny the claim.
- If the dates are overlapping, look to see if there are leave days on the LTC claim. The leave days must equal or be greater than the amount of days billed by hospital stay.
- Exception: If the revenue code is 250 (drug, supply) look at the billed amount, if they are the same deny the claim. If the billed amount is different for revenue code 250, force to pay.

NOTE: Leave day revenue codes are 180-185. You may have to count the days if they are overlapping. Example: If the hospital claim has four days, then the LTC claim must have four days for leave days and no more. Force to pay.

On bed rate revenue codes, 100-179, 200-219, and 230-239 you cannot be in two beds at one time. Exception: If one claim is a LTC claim and the provider is billing leave days.

Inpatient Xovers Versus Inpatient Xovers:

- Click on the related history claim(s).
- Check dates of service.
- If the dates of service are the same or overlapping, deny the claim.
- If the dates of service are a continuation, force to pay.

Exception: If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same Deny the claims. If the billed amount is different on revenue code 250, Force to pay. On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time.

Inpatient Xovers versus Outpatient Xovers:

- Click on the relate history claim (s).
- Check the dates of service.
- Check the revenue/procedure codes. If the revenue codes are on both claims., deny the claim.
- If the revenue codes are different, force to pay
- If one of the claims has a procedure code with a revenue code, force the claim to pay.

Exception: If the revenue code is 250 (which is drug supply), look at the billed amount. If they are the sam, deny the claims. If the billed amount is different on revenue code 250, force to pay. On bed rate revenue codes 100-179, 200-219, and 230-239, you cannot be in two beds at one time.

Inpatient versus Home Health:

- Click on the related history claim (s).
- Check the dates of service.
- Check the revenue/procedure codes.
- If the revenue codes are on both claims, deny the claim.
- If the revenue codes are different, force the claim.
- If one of the claims has a procedure code with the revenue code, force the claim to pay.
- If the sates of service are overlapping., deny the claim.

Exception: If the revenue code is 250 (which is drug supply), look at the billed amount, if they are the same, deny the claims. If the billed amount is different on revenue code 250, force to pay.

Audit: ESC 5008 Suspect Duplicate Header*Note: Audit 5008 revised July 23, 2003.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	Suspend
Adjustments	Suspend
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

All Crossovers**Case 1**

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Case 2

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient number and same or overlapping dates of service as a paid claim in history or a claim that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

5012 – Ancillary charges are not reimbursable on an outpatient claim when a surgical procedure is paid by ASC pricing. All charges are inclusive in the ASC payment.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors are found, compare current claim with history claim and determine if the claims are the same, or in case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim.
- In Cases 1 and 2, if the history claim is a LTC claim, check to make sure that the LTC claim was billed with a room revenue code (for example, 120) or a leave day code (180). If the LTC claim was billed with either of these revenue codes and the current claim was not, then override the audit.
- If an inpatient (or inpatient crossover) claim dupes against an outpatient (or outpatient crossover) or a home health claim, then override the audit.
- If duplication exists, deny the claim.
- If no duplication exists, override the error.

Note: If a claim suspends and a provider is billing for a bed rate code of 100 through 199 only pay one claim. These codes are related to the accommodation revenue codes listed on procedure group 59. The patient cannot be in two beds at one time.

Note: In the Related History window, these claims will show up as duplicating off of a detail. Ignore this and work the claim as normal. The system cannot list the related history as a header, even though in the dupe logic it is looking at the header.

Method of Correction for EOB 5012

- **If ancillaries are already paid when a surgery code claim suspends**
 - Force duplicate audit
 - Write down ICN related to the ancillary claim and give it to the team lead
 - The team lead will write up an adjustment to recoup any dollars reimbursed for the ancillary charges
- **If the surgery has been paid and the claim with ancillary codes suspends**
 - Deny ancillary services and add EOB 5012

Audit: ESC 5008 Suspect Duplicate Header*Note: Audit 5008 revised January 10, 2003.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit:

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

All Crossovers**Case 1**

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Case 2

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient number and same or overlapping dates of service as a paid claim in history or a claim that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors are found, compare current claim with history claim and determine if the claims are the same, or in case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim.
- In Cases 1 and 2, if the history claim is a LTC claim, check to make sure that the LTC claim was billed with a room revenue code (for example, 120) or a leave day code (180). If the LTC claim was billed with either of these revenue codes and the current claim was not, then override the audit.
- If an inpatient (or inpatient crossover) claim dupes against an outpatient (or outpatient crossover) or a home health claim, then override the audit.
- If duplication exists, deny the claim.
- If no duplication exists, override the error.

Note: *If a claim suspends and a provider is billing for a bed rate code of 100 through 199 only pay one claim. These codes are related to the accommodation revenue codes listed on procedure group 59. The patient cannot be in two beds at one time.*

Note: *In the Related History window, these claims will show up as duplicating off of a detail. Ignore this and work the claim as normal. The system cannot list the related history as a header, even though in the dupe logic it is looking at the header.*

Audit: ESC 5008 Suspect Duplicate Header

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C, I	20	All	Detail	Yes	Yes	0

Disposition	A, B, C, I
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	N/A
Adjustments	Suspend
Special Batch	Suspend

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit.

All Crossovers**Case 1**

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Case 2

The claim being submitted has the same recipient and provider number, same or overlapping date of service, and same coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Inpatient Claims

The claim being submitted has the same recipient number and same or overlapping dates of service as a paid claim in history or a claim that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

- Compare claim with suspense screen and check for keying errors. Correct any keying errors found.
- If no keying errors are found, compare current claim with history claim and determine if the claims are the same, or in case of overlapping dates, if some of the services on the current claim could have been previously paid by looking at the history claim.
- In Cases 1 and 2, if the history claim is a LTC claim, check to make sure that the LTC claim was billed with a room revenue code (for example, 120) or a leave day code (180). If the LTC claim was billed with either of these revenue codes and the current claim was not, then override the audit.
- If an inpatient (or inpatient crossover) claim dupes against an outpatient (or outpatient crossover) or a home health claim, then override the audit.
- If duplication exists, deny the claim.
- If no duplication exists, override the error.

Note: In the Related History window, these claims will show up as duplicating off of a detail. Ignore this and work the claim as normal. The system cannot list the related history as a header, even though in the dupe logic it is looking at the header.

Audit: ESC 5009 Suspect Duplicate Different Prov/Allowed*Note: Audit 5009 revised April 20, 2006.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C	20	All	Header	Yes	Yes	0

Disposition	A, B	C
Paper Claim	Deny	Pay
ECS	Deny	Pay
Shadow	Inactive	Inactive
POS	Deny	N/A
Adjustments	Deny	Pay
Special Batch	Deny	Pay

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5000.

All Crossover Claims

The claim being submitted has the same recipient number, different provider number, same dates of service, and different coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate/Claim service.

Method of Correction

Claims failing this audit systematically post and pay or deny depending on the claim type.

Audit: ESC 5009 Suspect Duplicate Different Prov/Allowed*Note: Audit 5009 revised March 31, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C	20	All	Header	Yes	Yes	0

Disposition	A, B, C
Paper Claim	Pay
ECS	Pay
Shadow	Deny
POS	N/A
Adjustments	Pay
Special Batch	Pay

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5000.

All Crossover Claims

The claim being submitted has the same recipient number, different provider number, same dates of service, and different coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

EOB Code

5000 – This is a duplicate of another claim.

ARC Code

18 – Duplicate/Claim service.

Method of Correction

Claims failing this audit systematically post and pay.

Audit: ESC 5009 Suspect Duplicate Different Prov/Allowed*Note: Audit 5009 revised January 10, 2003.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C	20	All	Header	Yes	Yes	0

Disposition	A, B, C
Paper Claim	Pay
ECS	Pay
Shadow	Deny
POS	N/A
Adjustments	Pay
Special Batch	Pay

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5000.

All Crossover Claims

The claim being submitted has the same recipient number, different provider number, same dates of service, and different coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

Once the claims are forced through edit 5000; have the claim go back through claims history and check all other related claims for exact duplicates.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

Claims failing this audit systematically post and pay.

Audit: ESC 5009 Suspect Duplicate Different Prov/Allowed

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, B, C	20	All	Header	Yes	Yes	0

Disposition	A, B, C
Paper Claim	Pay
ECS	Pay
Shadow	Deny
POS	N/A
Adjustments	Pay
Special Batch	Pay

Audit Description

Fail this audit when the claim being processed is a suspect duplicate of a claim(s) on the history file or another claim being processed in the same cycle.

Audit Criteria

Compare the claim being processed with paid claims in history and other claims being processed in the same cycle, if another claim is found with the following matches, fail this audit with EOB 5000.

All Crossover Claims

The claim being submitted has the same recipient number, different provider number, same dates of service, and different coinsurance and/or deductible as a paid claim in history or a claim that has been approved to pay.

EOB Code

5000 – This is a duplicate of another claim.

Method of Correction

Claims failing this audit systematically post and pay.

Audit: ESC 5010 Exact Duplicate – Tooth Surface*Note: New Audit 5010 March 31, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D	20	All	Detail	Yes	Yes	0

Disposition	D
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the detail being processed is a duplicate of a detail(s) on the history file or another detail being processed in the same cycle and the procedure code billed is listed on *Procedure Group 136, 137, 138, or 139* (refer to *Appendix A*).

Audit Criteria

If the submitted detail has the same billing provider number, same procedure code, same recipient number, same dates of service, same tooth number, and same tooth surface as a paid detail in the history file or another detail in the same cycle approved to pay, and the procedure code is listed on *Procedure Group 136, 137, 138, or 139*, fail this audit with EOB 5010. Codes listed on *Procedure Group 142* (refer to *Appendix A*) will bypass duplicate audits 5000, 5001, 5010, and 5011.

EOB Code

5010 – Exact Duplicate – Reimburse only one restoration code, per tooth, per day, per dentist.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

M58 – Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Method of Correction

Claims failing this edit will systematically deny.

Audit: ESC 5010 Exact Duplicate – Tooth Surface*Note: New Audit 5010 December 14, 2001.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D	20	All	Detail	Yes	Yes	0

Disposition	D
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the detail being processed is a duplicate of a detail(s) on the history file or another detail being processed in the same cycle and the procedure code billed is listed on *Procedure Group 136, 137, 138, or 139* (refer to *Appendix A*).

Audit Criteria

If the submitted detail has the same billing provider number, same procedure code, same recipient number, same dates of service, same tooth number, and same tooth surface as a paid detail in the history file or another detail in the same cycle approved to pay, and the procedure code is listed on *Procedure Group 136, 137, 138, or 139*, fail this audit with EOB 5010. Codes listed on *Procedure Group 142* (refer to *Appendix A*) will bypass duplicate audits 5000, 5001, 5010, and 5011.

EOB Code

5010 – Exact Duplicate – Reimburse only one restoration code, per tooth, per day, per dentist.

Method of Correction

Claims failing this edit will systematically deny.

Audit: ESC 5011 Possible Duplicate – Tooth Surface*Note: New Audit 5011 March 31, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D	20	All	Detail	Yes	Yes	0

Disposition	D
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the detail being processed is a duplicate of a detail(s) on the history file or another detail being processed in the same cycle and the procedure code billed is listed on *Procedure Group 136, 137, 138, or 139* (refer to *Appendix A*).

Audit Criteria

If the submitted claim has the same **or** different billing provider number, same first three digits of the procedure code, same recipient number, same dates of service, same tooth number, same tooth surface, and a code listed on *Procedure Group 136, 137, 138, or 139* as a paid detail in the history file or another detail in the same cycle approved to pay, fail this audit with EOB 5011. Codes listed on *Procedure Group 142* (refer to *Appendix A*) will bypass duplicate audits 5000, 5001, 5010, and 5011.

EOB Code

5011 – Possible Duplicate – Reimburse only one restoration code, per tooth, per day, per dentist.

ARC Code

62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Remark Code

M58 – Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Method of Correction

Claims failing this edit will systematically deny.

Audit: ESC 5011 Possible Duplicate – Tooth Surface*Note: New Audit 5011 December 14, 2001.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D	20	All	Detail	Yes	Yes	0

Disposition	D
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

Audit Description

Fail this audit when the detail being processed is a duplicate of a detail(s) on the history file or another detail being processed in the same cycle and the procedure code billed is listed on *Procedure Group 136, 137, 138, or 139* (refer to *Appendix A*).

Audit Criteria

If the submitted claim has the same **or** different billing provider number, same first three digits of the procedure code, same recipient number, same dates of service, same tooth number, same tooth surface, and a code listed on *Procedure Group 136, 137, 138, or 139* as a paid detail in the history file or another detail in the same cycle approved to pay, fail this audit with EOB 5011. Codes listed on *Procedure Group 142* (refer to *Appendix A*) will bypass duplicate audits 5000, 5001, 5010, and 5011.

EOB Code

5011 – Possible Duplicate – Reimburse only one restoration code, per tooth, per day, per dentist.

Method of Correction

Claims failing this edit will systematically deny.

Edit: ESC 5212 Disposition Amount for Adjustment is Less Than Zero*Note: New Edit 4246 effective August 16, 2005.*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	42	All	Header	No	Yes	0

Disposition	P	Q
51 Voids/Replacement check related	Suspend	Suspend
66 Replace Waiver Audit check related	Suspend	Suspend

Edit Description

The cash adjustment paid amount, plus the cash dispositions for the adjustment, must equal the mother claim paid amount, or the claim will suspend.

Edit Criteria

This edit is executed for adjustment transactions that contain a corresponding cash control number. This edit ensures that the daughter's amount paid - the mother's amount paid can be dispositioned against the cash receipt for the cash control number. The mother's fund code is used for dispositioning. If the claim has one program, there will be only one fund code and it is related to the header. If the claim has more than one program, the detail's fund codes are used. The claim can contain more than one fund code. If the claim contains more than one fund code, the detail amount paid for all details matching that fund code are processed (daughter-mother), to determine the amount to be dispositioned. This will repeat for each fund code. If the amount to be dispositioned for the fund code is less than zero, post the edit.

EOB Code

8998 – Claim being reviewed.

ARC Code

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes, whenever appropriate.

Remark Code

N35 – Program/Integrity/Utilization review decision.

NCPDP Reject Code

85 – Claim not processed.

Method of Correction

Work edits accordingly based on claim disposition amount and the cash receipts amounts. When errors have been corrected force edit 4246 with EOB 9998. If reason for amount discrepancy cannot be determined, seek assistance from the adjustment/financial unit prior to working this edit.

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